GENTLE DENTAL
ULLADULLA

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Welcome, and thank you for visiting us at Gentle Dental

For us to provide our patients with treatments at the highest standard, we require the following information. It will be handled with the utmost confidentiality. Please take your time to fill in the details below.

Patient Details

Title: ☐ Dr ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other

Surname: _____ First Name: _____ Middle Initial: _____

Preferred Name: _____ Date of Birth: _____

Residential Address: _____

City: _____ State: _____ Postcode: _____

Postal Address (If different): _____

Phone: _____ Mobile: _____ Work: _____

Email: _____

☐ Please check if you would not like to receive email correspondence (Confirmations, appointment reminders)

Private Health Fund Dental Cover? ☐ Yes ☐ No Private Health Fund: _____ IRN: _____

Medicare Number: _____ IRN: ___ Expiry: _____

Veterans Affairs (DVA) Number: _____ ☐ Gold ☐ White

Healthcare Card Number: CRN _____ Expiry: _____

Emergency Contact Name: _____

Relationship to patient: _____ Phone / Mobile: _____

Dental History

Last Dental Visit (approx.): _____

Have you ever had any complications or reactions following dental treatment in the past? ☐ Yes ☐ No

If yes, please specify: _____

Are you under the care of a specialist (Dental and/or non-Dental)? ☐ Yes (Please specify below) ☐ No

Name of specialist: _____ Type of specialist: _____

Phone: _____ Address: _____

Allergies

☐ None ☐ Yes (Please tick all that apply below)

☐ Aspirin ☐ Chlorhexidine ☐ Dairy ☐ Iodine ☐ Latex ☐ Penicillin

☐ Other (Please specify) _____

Please continue to page 2 for Medical History

Medical History

☐ Angina	☐ Blood Pressure	☐ Hepatitis	☐ Reflux/Stomach Problems
☐ Artificial Heart Valve	○ High ○ Low	○ A ○ B ○ C ○ D	☐ Respiratory Problems
☐ Artificial Joints	☐ Diabetes	☐ Kidney / Liver disease	☐ Rheumatic Fever
☐ Asthma	○ Type 1 ○ Type 2	☐ Neurological Disorders	☐ Sinus Problems
☐ Arthritis	☐ Dementia	☐ Osteoporosis	☐ Steroid Therapy
☐ Autism	☐ Epilepsy	☐ Pacemaker	☐ Stroke
☐ Blood Thinner Medication	☐ Heart Disease	☐ Parkinson's	☐ Cancer (Specify below)
☐ Bleeding Disorder	☐ Heart Murmur	☐ Psychiatric Care	_____
☐ Emphysema / COPD	☐ HIV (AIDS)	☐ Radiation / Chemotherapy	_____

☐ Other (Please specify): _____

Are you currently taking medication (including natural supplements)? ☐ Yes ☐ No

If yes, please specify: _____

*** If you are on a daily schedule of prescriptions, please provide us with details of your GP and your prescription schedule.**

GP: _____ GP Phone: _____

Please Choose: ☐ Smoker (incl. vaping) ☐ Non-Smoker ☐ Ex-Smoker

Are you pregnant? ☐ Yes ☐ No If yes, expected due date: _____

Are you suffering from any of the following?

☐ Bad appearance of teeth	☐ Discoloured teeth	☐ Lost filling / Cavity	☐ Sleeping problems
☐ Bad breath	☐ Dry mouth	☐ Pain in face / jaw	☐ Unsatisfactory denture
☐ Bleeding gums	☐ Grinding / Clenching teeth	☐ Sensitive teeth	☐ Worn or broken teeth
☐ Chewing difficulties	☐ Missing teeth	☐ Sounds from jaw joint	
☐ Decaying teeth	☐ Loose teeth	☐ Snoring	

Have you ever had a sleep study done and been diagnosed with sleep apnoea? ☐ Yes ☐ No

If yes, have you ever tried Continuous Positive Airway Pressure (CPAP) therapy? ☐ Yes ☐ No

How did you hear about us?

☐ Web / Google ☐ Yellow pages ☐ Word of mouth ☐ Location ☐ School ☐ GD Staff

☐ Other (please specify): _____

☐ Referred by family / friend: _____

Consent for service

To the best of my knowledge, all medical history information provided is accurate and correct. If required, I give authority for Gentle Dental to acquire medical records on my behalf from the medical practitioner provided on this form. I hereby give consent for any treatment required and agreed upon by me, to be carried out by the providers and staff of Gentle Dental. I agree to be responsible for payment of all services rendered on my behalf and my dependents' behalf. I understand that unless prior arrangements are made, **all payments** must be settled at the time of service.

Signature of patient, parent, or guardian: _____ Date: _____

Relationship to patient: _____